

To Section 4.13-jes

## Health Certificate (to be completed by a doctor of medicine – physician, MD, medical practitioner – only)\*

(\*If your place of residence is less than 50 km from a German embassy, this form must only be completed by a doctor duly accredited by the embassy. The embassy will provide you with the relevant contact details.)

**Please fill in the form clearly and legibly in BLOCK CAPITALS or by typewriter!!!**

DAAD Registration No.  
(Personenkennziffer/PKZ)

Surname/ \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Family Name:

Scholarship Holder

First Name: \_\_\_\_\_

Spouse

Address: \_\_\_\_\_

Child

1. Height: (          cm)          Weight: (          kg)          Sex:  m  f

2. Blood pressure (mm/Hg)          Pulse in resting state:  
 lying:                                      after 10 knee-bends:  
 standing:                                    after 2 minutes:

| 3. Does or did the candidate have any of the following illnesses/diseases? | No                       | Yes                      | Is any treatment/medication still required? (see Point 4 on Page 2) |
|--|--------------------------|--------------------------|---|
| 3.1 Allergies  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.2 Abdomen/including urinary tract  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.3 Locomotor system (spinal/vertebral column/joints)                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.4 Bronchial asthma   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.5 Diabetes   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.6 Sexually-transmitted/venereal diseases                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.7 Skin   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.8 Hepatitis  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.9 Cardiovascular system  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.10 Gastrointestinal tract  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.11 Neurological disorders  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.12 Mental or psychological disorders                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.13 Rheumatism  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3.14 Thyroid gland   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  |

DAAD Registration No.  
(Personenkennziffer/PKZ):

Name: \_\_\_\_\_

4. What other treatment is required or planned (possibly including any medication)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. For females: Is the candidate expecting to give birth in the near future? No Yes

If yes: When is she expected to give birth (delivery date)? \_\_\_\_\_

6. Any particular findings made regarding viral and/or infectious diseases (e.g. hepatitis A, B, C/ HIV infection, malaria, rheumatism)?

If yes, please specify? Please make sure you include the findings: \_\_\_\_\_

7. **Summary: Are there any reasons why the candidate's state of health should give reason for him/her not to complete a study or research stay in Germany?**

No Yes

Place: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor's Signature and Stamp: \_\_\_\_\_